Virginia Department of Medical Assistance Services
Patient Pay
Fact Sheet 2015

Determining the Amount of Patient Pay

Patient Pay is defined as the amount of a member's income that must be paid toward the cost of his or her Medicaid Long-term Care (LTC) Services.

All members must have a patient pay calculated, but not all members have a contribution to pay to the LTC provider. Whether an amount is due to be paid depends upon the type and amount of a member's income and allowable deductions.

The local Departments of Social Services (LDSS) are responsible for determining the amount of the patient pay contribution, if any, the member must make.

Nursing Facility members may have a maximum of $40.00 per month deducted for their basic allowance each month. Members whose only source of income is Supplemental Security Income will only receive $30.00 per month from the Social Security Administration.

Home and Community Based Services members may have a maximum of $1,209 per month deducted from their income for their basic allowance each month.

Adjustments to the amount of patient pay may only be completed prospectively by the LDSS. For adjustments involving non-covered medical expenses, the deduction may only be made after delivery of the service for which the deduction was requested.

Adjustments for non-covered medical expenses that exceed the amount of the member's contribution continue to be deducted until the bill amount has been exhausted.

If the total amount of a medical service or durable medical equipment exceeds $500, the adjustment must be approved by DMAS prior to the service being rendered. However, in no case may the adjustment be allowed prior to the member receiving the services or equipment for which the request was submitted. After a request is approved if a change is required, a new request must be submitted for authorization. The amounts of these adjustments are limited to the Medicare rate if available or the Medicaid rate if no rate was established by Medicare for that particular service or item.

The cost of a health or dental insurance premium may only be deducted after the member has paid the premium amount.

All requests for deduction whether evaluated by the LDSS or DMAS must meet Medicaid policy requirements in order for the deduction to be allowed.

Patient Pay is paid directly to the provider of LTC Services by the member or their representative.

Patient Pay Communication

The DMAS-225 is the approved communication form between LTC providers and the LDSS. This form is only used to communicate initial eligibility, change in eligibility status, penalty period information and changes in insurance. Prompt submission of this form is necessary to insure that patient pay will be revised timely. This form is not used for communicating the amount of patient pay.

The Notice of Obligation of LTC Costs is utilized by the local Departments of Social Services (LDSS) to advise the member/their representative of the amount of the member's patient pay.

Providers must use the ARS or Medicall real-time systems to obtain verification of patient pay amounts. Institutional LTC providers may also use the ASO-317 report in addition to the real-time verification sources.

Patient Pay and Claim Payments

For each LTC claim, DMAS determines the allowed amount and deducts any copays, third party payments and patient pay to determine the amount paid on the claim.

For dates of service through the month of March 2015, LTC providers are responsible for submitting patient pay on the claim. This is the amount used to determine payment. It has been the practice that one provider is responsible to collect patient pay from the member and deduct it from its claims.

For dates of service beginning in the month of April 2015, DMAS will automatically enter the patient pay on the claims from its records submitted by the LDSS. If there are multiple claims from LTC providers (the same provider or multiple providers), DMAS will track the amount of patient pay allocated to each claim on a first adjudicated basis.

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